

CPA, Inc.
420 Washington St. Suite LL8
Braintree, MA 02184
781.848.9848 (Direct)
781.848.8477 (Fax)
www.CPA125.com

AUTHORIZATION FOR PAYROLL REDUCTION

This signed form must be returned to CPA, Inc. by 10/15/05

EMPLOYER: Town of Westford

PLAN YEAR: 11/1/05 - 10/31/06
(expenses must be incurred between these dates)

→SSN _____ - _____ - _____

Home Phone: Home Phone

→E-Mail: _____

Pay Cycle: Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other: _____

Benefit Description		Annual Amount	For Internal Use Only	For Internal Use Only
Dependent Care	→	\$		
Medical/Dental Expenses	→	\$		
Other (COBRA or Non-Payroll Premiums)	→	\$		
Administrative Fee		\$		

I hereby authorize a salary reduction for the amount(s) shown above. I understand that:

- This election cannot be revoked or changed during the plan year without a qualifying event as defined in the IRS regulations.
- Dependents must qualify under regulations set forth by the IRS.
- Services must be provided during the plan year noted above.
- Services must be consistent with allowable medical deductions under the IRS Code.
- This signed form must be received by CPA, Inc. prior to or on the deadline noted above to be eligible for the plan year.
- Re-enrollment in this plan is not automatic.

Signature: _____ Date: _____

Direct Deposit Authorization on the back*

*Required for automatic dependent care reimbursement

*does not need to be completed if already enrolled in direct deposit

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